

VOLUME 4

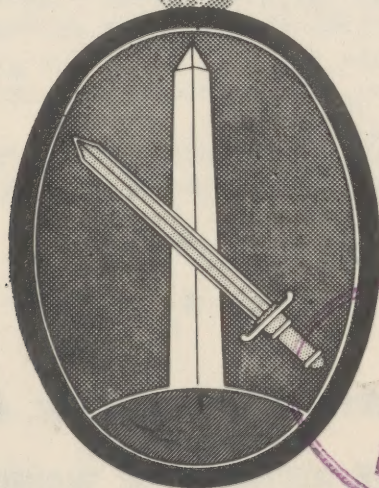
REPORT NO. 11

RESTRICTED

Security Information

MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

Security Information

ARMY
MEDICAL
DEC 18 1951
LIBRARY

November 1951



**THIS DOCUMENT CONTAINS INFORMATION
AFFECTING THE NATIONAL DEFENSE OF
THE UNITED STATES WITHIN THE MEANING
OF THE ESPIONAGE LAWS, TITLE 18, U.S.C.,
SECTIONS 793 AND 794. THE TRANSMISSION
OR THE REVELATION OF ITS CONTENTS IN
ANY MANNER TO AN UNAUTHORIZED PER-
SON IS PROHIBITED BY LAW.**

This "Monthly Health Bulletin" invites every reader to participate in its preparation by contributing articles. There must be something in the daily military experiences that will interest others and possibly be helpful to others. Administrative directives, professional articles, clinical notes, descriptions of new devices and instruments are welcomed. While the number of copies of this publication is not great, there is a wide distribution, geographically speaking.

Contributions should be addressed to The Surgeon, MDW, Room 2D-201, The Pentagon, Washington 25, D. C.



**MAJOR GENERAL THOMAS W. HERREN
COMMANDING
MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.**

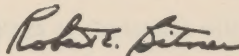



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

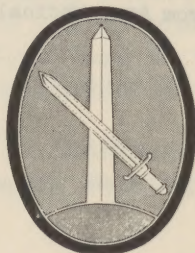
Contributions; as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.



ROBERT E. BITNER
Colonel, MC
Surgeon

CONTENTS

	PAGE
ADMINISTRATIVE SERVICE	
If Washington is Hit By A-Bomb Food Suppliers are Ready to Feed Survivors. . . 10	10
Army Returns Handicapped Veterans to Full Duty Positions 11	11
Access To and Release of Information from Army Records to the Public 12	12
Alphabetical Index to Medical Technical Bulletins, with Cross-References . . 13	13
A Partial Explanation of Codes Used in Evaluation of Reserves. 18	18
Table -- Hospital Mess Administration 26	26
Table -- Outpatient Service. 26	26
DENTAL SERVICE	
Table -- Dental Service 26	26
PREVENTIVE MEDICINE	
Combat Exhaustion 1	1
Trends in Venereal Disease Control 5	5
Cold Weather Increases Carbon Monoxide Hazard. 7	7
Is Cancer Research Getting Anywhere? 8	8
Returning Korea Veterans to Receive New Antimalarial Drug. 9	9
General Comment 20	20
Communicable Disease 20	20
Table -- General Data. 21	21
Table -- Admissions, Specified Diseases. 21	21
Venereal Disease 22	22
Table -- New Venereal Disease Cases. 22	22
Chart -- Admission Rates of Common Respiratory Disease and Injury. . . . 23	23
Chart -- Venereal Disease Admission Rates by Month 23	23
Chart -- Venereal Disease White Rates. 24	24
Chart -- Venereal Disease Negro Rates. 24	24
Chart -- Venereal Disease Total Rates. 24	24
Table -- Venereal Disease Rates for US 25	25
Table -- Consolidated Venereal Disease Statistical Report. 25	25
VETERINARY SERVICE	
Trichinosis 19	19
Table -- Veterinary Service. 26	26

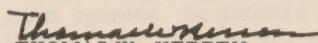




Season's Greetings

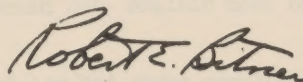
My sincere wishes to all of you for a very merry Christmas! This year we face the traditionally happy season with gratitude for our blessings and the wish to share those blessings with the rest of the world. Our love of peace and the desire to establish it on a permanent, world-wide foundation is coupled with our inherent will to defend the oppressed. These emotions underlie our observance of Christmas.

The goal of peace and good-will set so long ago - on Christmas - is worthy of our best efforts. We are proud to share in working toward its achievement. May the New Year, with God's help, bring it closer within our grasp and make 1952 the happiest year this earth has known.

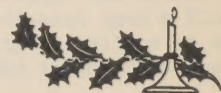

THOMAS W. HERREN
Major General, USA
Commanding



I wish to add my personal wishes to those of the Commanding General, in expressing the hope that the blessings of Christmas will be carried forward into the New Year, and that 1952 will bring goodwill to all men.



ROBERT E. BITNER
Colonel, MC
Surgeon, MDW



PREVENTIVE MEDICINE

COMBAT EXHAUSTION

By

Colonel Albert J. Glass, MC
Psychiatric Consultant, GHQ, FEC

The term "Combat Exhaustion" is applied to the well-known acute psychiatric battle casualty to designate a temporary psychological failure of the soldier to function adequately in a combat situation. The manifestations of combat exhaustion are diffuse and may involve both the psychic and somatic spheres. Characteristically the signs and symptoms are quite variable. The clinical picture may change in a matter of hours or from day to day. Many cases are mild, as exemplified by those individuals who only verbalize the subjective sensations of fear in battle with no objective evidence of anxiety. Other psychiatric casualties are more severe, with tearfulness, depression, gross tremulousness, or hysterical blindness and paralysis. A smaller group of cases exhibit such a severe disruption of personality function that they are out of contact with their environment and present a transient psychotic syndrome.

The acute mental breakdown of combat is an age-old phenomenon. Even the bible records the panic and paralyzing fright of participants in battle. It has always been considered good military strategy to weaken and disorganize the enemy by utilizing the crippling effects of fear stimuli. The use of bugles, cymbals and whistles as currently employed by the Chinese troops is an ancient maneuver of this type. Indeed, the Walls of Jericho were figuratively, at least, disintegrated by the blowing of a trumpet. In modern warfare, artillery fire and air attacks are the most prolific producers of fear as well as actual battle casualties. It is an old military axiom that one never wastes artillery shells so long as they are hurled at the enemy. Even animals utilize fear-producing tactics, as exemplified by the roaring of the lion which renders the victim helpless before the actual attack.

It is evident that any method designed to increase the strength and number of fearful stimuli may serve to undermine the ability of individuals to react aggressively to a source of danger. This occurs because the subjective sensations of fear are never helpful to the person but are painful. They make it difficult for him to think logically, and operate to inhibit physical activity. Only the physiological concomitants of fear are valuable in that they prepare and support the soldier for the increased bodily demands required for fight or flight.

The emotional overtones inherent in the words used to label the combat psychiatric casualty are of major importance; they affect the attitude of the patient towards his condition as well as influence the opinion of his fellow soldiers, friends, and family. Prior to the advent of modern medicine, the emotional upheaval in battle was designated by lay terminology indicative of paralyzing fear or flight with the moral connotation of cowardice.

It has been only since World War I that military medicine has been called upon both to prevent and treat psychiatric casualties in an effort to better conserve the fighting strength. Because the largest fear and casualty producing agent was artillery fire, mental breakdown in battle became known as "shell-shock." This term, although descriptive, was unfortunate because it produced confusion and unclear thinking on the part of the patient and the physician. Medical officers debated amongst themselves as to the amount of brain damage present because of the inevitable history of a nearby explosion. Patients were easily influenced to believe then, as today, that their symptoms were a logical result of an outside force which caused irreparable injury to the mind. They readily took the view which removed personal responsibility for an emotional conflict. The entire syndrome was fostered and fixated by prolonged hospitalization with subsequent evacuation to the ZI. Following World War I, it became generally recognized that "shell-shock" was primarily a psychological problem, and that the effect of air blast upon the head could not explain most of the immediate symptoms and all of the later persistent illness.

At the outset of World War II, the pendulum had swung completely to the view that the emotional disruption of battle was an acute traumatic neurosis and should be classified accordingly. As a result, in the early phases of World War II, psychiatric casualties were designated as "psychoneurosis, anxiety state," "anxiety reaction," "psychoneurosis mixed," "conversion hysteria," etc. This nomenclature, like "shell-shock," proved to be misleading to the medical officer and traumatic to the patient. It unnecessarily conferred the diagnosis of a fixed neurotic disease upon a fluid and transient emotional disorders. Again, it influenced the psychiatric casualty to believe he was suffering from a serious mental illness for which there was a poor prognosis and in which he could

PREVENTIVE MEDICINE

readily utilize the secondary gain mechanism of illness to displace responsibility for his symptoms and behavior upon the working of his unconscious mind.

Obviously, a new diagnostic category was needed. In 1943, the designation "combat exhaustion" was originated to convey a more realistic appreciation of a transient psychological breakdown caused by battle stress, which might occur in individuals with or without neurotic predisposition. The word "exhaustion" gave the connotation of a logical result of combat from which one can recover by such ordinary means as rest and recuperation. This diagnosis quickly became popular and was adopted by all branches of the service with such modifications as "combat fatigue," "flying fatigue" and "operational fatigue."

After the initial confusion of the Korean campaign, "combat exhaustion" became the standard diagnosis to categorize the acute psychiatric casualty among divisional or other troops in the forward areas. However, other definitions have already begun to creep in and distort the original meaning of the term. On the one hand, some have reverted to the past and regard combat exhaustion as a fancy name for being cowardly or yellow; on the other, it has become confused with physical exhaustion and considered an organic disease. It is the purpose of this paper to clarify the concept of combat exhaustion and to explain its complex etiology which may include physical factors. It is hoped that a better understanding of the problem will point to logical methods prevention and early treatment which are vitally necessary to conserve and salvage the fighting strength of our troops.

It has been stressed that the instinctive fear of the loss of one's life is the primary or basic cause of combat exhaustion. Yet this is too simplified a concept, similar to considering that the tubercle bacillus is the cause of the active disease. As in tuberculosis, it should be recognized that there are multiple causative factors, such as individual susceptibility to the disease, the amount and intensity of the dosage of the traumatic agent, and the lowering of sustaining powers against illness, called resistance. These are of far more importance in producing the clinical disease than the ubiquitous fear of death in battle, which, like the germ of tuberculosis, is present in almost everyone.

When attention is shifted from the threat to life as the major cause of combat exhaustion to an examination of individual susceptibility and the sustaining powers which prevent fear from overwhelming the person, a new way is opened for a more fruitful understanding of the entire problem.

In considering individual susceptibility to emotional breakdown, it must be conceded that all persons do not have the same capacity of adjustment to stressful situations. In combat it is particularly necessary that the soldier be able to mobilize and externalize aggression, in order to adequately cope with the enemy. The timid, passive person who has never had a fight and who rarely fires his rifle is especially vulnerable to fear because he is unable to discharge tension by hostile action. Consequently, anxiety builds up rapidly and becomes uncontrollable. To a lesser degree, the overly careful or overly aggressive individual is more susceptible to combat stress because such character traits have been developed as a protection against excessive inner feelings of insecurity and dependency. Continuous combat produces a collapse of the hitherto effective defenses of the individual with the consequent rise of unbearable tension.

Another component of the personality which contributes to the adjustment of the combat soldier is the conscience. This is the well-known internal policeman that forces one to perform unpleasant, distasteful and even dangerous tasks, because of duty, honor, self-esteem and self-respect. Individuals with an average degree of this conscience element are internally compelled to keep going on in battle despite terror and a wish to flee or be helpless. Self-esteem is a potent force in human behavior and is deeply ingrained in individuals of our western civilization. It is responsible for the phrase, "I have to live with myself." If the strength of the conscience is low, the soldier lacks an internal compelling agency and more readily allows himself to be overcome by external stress. If the conscience is overly severe, it punishes the person for even the unavoidable disastrous episodes so common in battle. This reaction is not infrequently observed in officers and non-commissioned officers who blame themselves for the normal vicissitudes and casualties among their men, despite the intellectual knowledge that such events are inevitable in combat. This feeling of guilt adds a further burden to the existing tension and may precipitate a mental breakdown.

The omnipresent fear of death and the individual susceptibility to combat stress are not sufficient to explain the causation in most cases of combat exhaustion. It is common knowledge that

PREVENTIVE MEDICINE

some combat units consistently have fewer psychiatric casualties than others, despite an equivalent or greater degree of battle stress. This discrepancy in psychiatric rates can be observed among the various units of a battalion, a regiment or a division. The distribution of vulnerable individuals is similar in all organizations and does not explain the disproportionate incidence of psychiatric breakdown. Another factor must be present. This can only be due to the influence of the group or combat unit which can offer realistic protection against external fear. The individual does not fight alone - around him are his buddies who share his dangers and deprivations and will aid him if he is disabled. The more confidence he has in his platoon or company the less fearful is the battle situation. When men fight together and share common tribulations, they become bound by the closest of emotional ties. This affection, which is akin to love, serves to lessen concern for one's own life, thereby decreasing the crippling subjective sensation of fear. That such an emotional bond is common has been repeatedly demonstrated by numerous instances where individuals have unhesitatingly performed dangerous and heroic deeds to save their friends. The grief reaction of a man who loses a buddy in combat is only comparable to the mourning over the loss of a loved one. The close kinship of man forged in battle is responsible for instances where soldiers prematurely leave the hospital or a rear assignment to rejoin their comrades.

Group identification begins in training. Here the soldier gains not only competence and confidence in the use of his weapons but also learns the value of team work in battle: the foundation for the protective functioning of the unit. Where additional training is given to the new replacement by the combat unit, it serves, rapidly and effectively, to integrate him into the group. Such a training policy for new replacements has been successfully adopted by divisional units in Korea when the tactical situation permitted. This acts as additional environmental support often needed by susceptible individuals to prevent an early breakdown in battle.

Even the timid soldier comes to feel secure by being in a powerful group and often assumes the aggressive attitude of the organization. The unwilling person with little internal compulsion for hazardous duty is literally forced to adopt the high standards demanded by his fellow-soldiers. The combat unit develops its own special characteristics which are quickly adopted by the new replacement; after a short time he talks and acts like any veteran member. In brief, the group offers protection against fear to the soldier and provides for his emotional needs, but demands that he give up personal desires and selfish considerations. In its simplest form, group identification is a matter of "united we stand, divided we fall."

The ability of a combat unit to achieve tactical success and to sustain its constituents against emotional breakdown is entirely dependent upon its leader. Napoleon's dictum "there are no bad soldiers, only bad officers," points to the crux of the problem of morale and combat effectiveness. Because the company grade officer lives in intimate contact with his men he plays a vital role in their motivation and group spirit. This officer is figuratively and literally a father figure. Like a good father he cannot be over-indulgent, but he must have a personal concern for the comfort and welfare of his men. Such a leader sets the standard and motivation for his organization by example and behavior. The poor combat leader is quickly recognized by his men for inapt tactical management, unfair treatment, and a callous disregard for their comfort and safety.

A member of an adequately led combat unit has an increased resistance to mental breakdown because of the emotional and actual support provided by the group. The failure of such an environmental support is the major cause for most cases of combat exhaustion. It explains the difference in psychiatric rates for various units. However, there are exceptions even in a well-led combat unit when unavoidable battle episodes occur and heavy casualties are suffered. The protection of the group is suddenly weakened or destroyed. It is at this time that psychiatric casualties may occur from the more susceptible members of the unit when they are left to face their danger alone. There are also occasions when the death or other removal of a combat commander may cause a disruption of the group, with consequent mental breakdowns, especially if a new leader, a platoon sergeant, for example, does not arise promptly to assume command.

A minor but pertinent cause of combat exhaustion is a lowering of the physiological state of the body. This occurs when men go without food and sleep for many days, or may be produced by such intercurrent diseases as malaria, diarrhea, and hepatitis. A decrease in physical ability to function adequately makes it difficult for the soldier to continue his aggressive adaptation and to control subjective sensations of fear. If not corrected, it may operate as "the straw that broke the camel's back" in its action as a precipitating agent to produce combat exhaustion. Unit commanders

PREVENTIVE MEDICINE

are well aware of this problem and attempt to insure periodic rest from combat with an opportunity to obtain hot food and sleep. Often the unit commander and the battalion surgeon act together to give particular individuals a 24 hour rest period at the aid station or some other suitable location.

The prevention of combat exhaustion must lie in the province of command. The medical officer has no inoculation against the virus of fear; moreover, it is impossible to select only mature, aggressive and well-motivated men for combat duty. The measures that will sustain the soldier from an emotional breakdown are identical with those required for a good tactical unit. The selection of capable combat leaders and the initiation and maintenance of group morale and motivation are the logical and profitable means of preventing the soldier from being overcome by battle stress.

The prevention of psychiatric casualties is a relatively simple process compared to treatment after the individual has suffered a mental breakdown. This can be done effectively and rapidly when the causes of combat exhaustion are understood and if there is a proper appreciation of the role played by the primary and secondary gain in illness. The primary gain in illness is readily recognized when one considers that sickness confers a gain of being helpless with an honorable reason for not fulfilling adult obligations. This explains the euphoria of soldiers who receive a non-serious battle wound. It accounts for the phrase "million dollar wound" which ineffect places the individual in a privileged status of being unavoidably removed from the difficult and dangerous job of a combat soldier. It is only after recovery from such a wound, when the individual is ready for discharge from the hospital, that tension and anxiety appear coincident with the removal of the advantages of illness. Any type of disease may provide an element of primary gain for the patient. This is equally true in civilian life where sickness is the best excuse for remaining away from work or onerous tasks. The psychiatric casualty also achieves a primary gain from his illness. Hysterical blindness and paralysis on the battle field duplicate disabling conditions and force the environment to remove them from the stressful situation. It should be emphasized that in wounds, diseases and most cases of combat exhaustion, the primary gain in illness is unconscious and not sought for directly by the individual. However, when the soldier uses the same symptomatology to avoid return to combat or to prevent assignment to non-combat duty, we note the phenomenon of the secondary gain in illness. It is an attempt by the individual to retain his patient status by the utilization of a similar pattern that produced the primary gain. This is demonstrated by the wounded soldier who upon recovery continues to have pain about the site of injury or operation and the psychiatric casualty who maintains his tremor, headache and tension even though quite removed from battle. The longer that patient remains away from his unit, in time and distance, the more vulnerable does he become to the fixation of secondary gain. He is removed from the sustaining influence of his organization and is no longer motivated by their attitude and standards.

The awareness of the factors of time and distance in the gain in illness mechanism can be effectively utilized in the treatment of combat exhaustion particularly if that illness is viewed as a temporary disruption of the protective powers of the group or a lowering of resistance of combat stress by physical factors. In actual practice the acute psychiatric casualty is readily salvaged, if after a period of relief from mental and physical stress he is promptly returned to his organization. This return contains the emotional support required to aid him in resuming his previous self-control. A treatment program which involves a 2-4 day period of rest and rehabilitation within the division area has the advantage of keeping the patient near his group where time and distance is not sufficient to permit the transition from primary gain into chronic secondary gain habits. Severe cases of combat exhaustion however, must be evacuated to rear hospitals and given a more prolonged relief from battle. This is especially true when individuals have been in combat for many months and have lost most of the members of their original group. At this rear level of treatment it is sound therapeutic management to return the patient to some useful non-combat job as soon as possible in order to circumvent the buildup of secondary gain symptoms, and to give the individual an opportunity to feel that he is still an effective member of the Army. After several months of a rear assignment, the former combat soldier often is ready to return to his original organization. Even the most serious cases that are evacuated to Japan are salvaged for effective non-combat duty by psychotherapy. This form of treatment insists that what has happened to the patient is a rational and logical series of events; that he cannot cling to the helpless state that originated in battle and that the overcoming of the neurotic mechanism is imperative to prevent a fixation of symptoms which would occur if he were returned to the ZI. Such further evacuation tends to place an additional burden upon the patient in that he must continue to have symptoms in order to explain to himself, his friends and family the reasons for his failure. If the pattern of secondary gain is repeated often enough the individual is rendered helpless for subsequent useful activity and there is produced the well known querulous, irritable, neurotic war veteran.

PREVENTIVE MEDICINE

What has been stated above in regard to the prevention and treatment of combat exhaustion can be applied with equal force to the emotional breakdowns in non-combat units whether they be located overseas or in the ZI. The factor of group identification which sustains the individual against the deprivations and vicissitudes of the environment operates in an identical manner in non-combat organizations. Here also, leadership is of equal importance in the maintenance of unit morale as it is in a combat organization. Similarly the treatment of psychiatric patients from non-combat units should be based on the principle of therapy near the location of origin, thus limiting the gain in illness.

SUMMARY:

Combat exhaustion is due to multiple factors, the most important of which is a decrease of the environmental support provided by the group or combat unit, permitting the soldier to be overwhelmed by external danger. The recognition of this concept facilitates a more rational application of the methods that can be employed in the prevention and treatment of this disorder.

* * * * *

TRENDS IN VENEREAL DISEASE CONTROL

By

A. L. Gray, M. D., Director
Division of Preventable Disease Control
State of Mississippi

The past fifteen years have witnessed dramatic changes in the venereal diseases picture. It is impressive to view the accomplishments which have taken place since 1936 when the people for the first time heard about syphilis and gonorrhea publicly through the efforts of Surgeon General Thomas Parran and his associates. "Why Don't We Stamp Out Syphilis" was the title of an arresting article appearing in the widely-circulated Reader's Digest just after a broadcasting station refused to allow the word "syphilis" to be used in a radio talk. Other lay magazines followed with articles which presented the problem forcefully and the public became stirred at the disgracefully high incidence of venereal disease which existed and which posed a serious national health problem. The problem became a focal point for renewed public health action as Congress appropriated funds to the U. S. Public Health Service which made it possible to initiate programs of venereal disease control at the national, state, and county levels.

A vigorous and effective educational program was launched, although there remained a considerable handicap in that there were really no effective therapeutic approaches which lent themselves to the control of these diseases on a mass basis. Much was needed in the form of diagnostic, epidemiologic, and even educational approaches to the eventual solution of the problem. The continuing research and work that followed bore fruit which well justified the vast amounts of federal, state and local funds which had to be expended. Improved diagnostic techniques were developed, case-finding methods became more effective, efforts at public education began to "take" where it was most needed, and finally the discovery of a simpler and more effective therapy opened the way to progress on a scale little dreamed of in the early, difficult days of the venereal disease control program.

For the most part this gigantic effort was financed in the beginning through federal funds. Certainly, without this financial assistance there would have been no uniformity of program and it is difficult to imagine how many years would yet have to pass before the present state of progress had been reached had each state endeavored to undertake the job alone. It is unfortunate, however, that basic legislation on a national level through which funds were provided to states for venereal disease control did not and perhaps could not stipulate the period of time for which federal aid might be expected. Neither was the rate of prospective financial aid to states related to the rate of decline of the problem. It would seem wise that federal support of control programs in regard to problems of this type might be planned either on a time basis or on the basis of the size of the problem.

In Mississippi in 1945, the rate of occurrence of primary and secondary syphilis for 5,000 population was 19. By 1947 this rate had declined to 10.1; in 1949 it was 4, and in 1950 it was 2.1. This represents a most satisfactory trend and compares favorably to trends in each of the other states

PREVENTIVE MEDICINE

and the nation as a whole. The whole trend today would seem to indicate that the problem of syphilis is rapidly shrinking from one of serious national concern to one of state and mainly local significance. In view of this, it will soon become evident that the large amounts originally spent on control can no longer be justified, and that the total cost of continuing the decline of incidence should follow the trend of incidence downward.

Syphilis, as a national problem, now has an incidence of approximately 3.2 early cases for each 5,000 population, but in some states that rate has dropped to one or less. Other states are rapidly approaching or passing this rate of one per 5,000 population. This may be considered a new milestone of achievement, and as the rate reaches or passes this milestone it is felt that it changes the problem from one of national concern to one of state and local responsibility. It should be recognized that the national effort has produced and made available acceptable tools for diagnosis and treatment which if properly applied will likely force this trend still further downward until the problem has reached a level of irreducibility.

Since there is no immunizing agent against syphilis, foci and pockets of infection remaining will have to be cleaned out and the permanent maintenance control program must be promoted and financed at state and local levels.

Maintenance control by health departments must include a 2-way flow of information telling the state officers and their venereal disease control directors where and in what amount of infection is concentrated in their states. It must also provide for a flow of educational information to local health departments which will keep professional groups informed and quite active in assisting in the control and the public alerted to the dangers of untreated syphilis at all times. The governor and members of state legislatures of the various states must be acquainted and impressed with the facts and requirements for maintenance control. State and local governmental agencies should be acquainted with the cost of residual and improperly treated syphilis. As this problem reaches the maintenance control level of roughly one new case per 5,000 population, we as venereal disease control workers must no longer look to Federal sources for the major share of control funds; instead we must secure required funds from state and local governmental agencies on the basis of accurate knowledge as to the remaining problem and the possibility of this problem again breaking out of the bounds of control. In other words, we must deal honestly and fairly with Congress and ask only for funds that are needed to continue the war on these diseases to the extent that they are national problems and where they have not already been reduced to a manageable point by local and state agencies.

If national forces are reintroduced in a given area of the nation which increase the problems of syphilis and gonorrhea in a given region of the nation as a whole, the financial burden for control should again be assumed in a large measure by the Federal government. It would be most unusual if any disease is brought under control simultaneously in all states. This means that there is a necessity for Federal aid in the future for venereal disease control to have flexibility which would permit discontinuing Federal aid to states in proportion to the required extent of the problem in each state. Federal financial assistance should not be discontinued for a given state when it has reached the maintenance level of one new case per 5,000 until after the state legislature of that state has had an opportunity to consider the matter of financing the maintenance control program and with full knowledge that Federal support is to be discontinued. Certainly the state legislators must be made acquainted with the fact that the pattern of human behavior responsible for the spread of venereal diseases has not changed nor will it likely change sufficiently to hold the incidence of the disease down to a maintenance level. They should also know that a watchtower of epidemiologic intelligence must be maintained over the entire state supported by diagnostic and treatment services available to all those suspected of or known to have infectious syphilis. In addition, they must know that this control patrol activity must be maintained and that it will cost money which for the most part must be provided by state and local agencies.

As the various states reach the maintenance level of roughly one new case per 5,000 population per year, it presents a new challenge to those in the state boards of health and local health departments responsible for venereal disease control. This challenge tells us that if we do not use every possible effort in getting state and local control, the national, state, and local efforts of the past fifteen years may be for the most part overshadowed and discounted by a resurgence of the problem. This challenge also means for the future we, as venereal disease control officers, and other workers must be even more concerned than in the past, for with the disease syphilis we can never afford to become complacent. The controllability of syphilis has been thoroughly demonstrated. It remains for us to demonstrate our ability to continue that control primarily through the use of state and local resources.

(The above article is from "State Board of Health", May 1951)

PREVENTIVE MEDICINE

COLD WEATHER INCREASES CARBON MONOXIDE HAZARD

Carbon monoxide, a gas resulting from incomplete combustion of solid, gaseous or liquid fuels, is a deadly poison. This gas is not readily detectable by sense of smell or taste, because when pure it is colorless, odorless, tasteless, and non-irritating.

Despite repeated warning about the dangers of carbon monoxide, all too often we still hear of narrow escapes or even deaths, due to air contaminated with this treacherous gas. Cold weather increases the danger. You have to take special care then not to inhale confined air fouled by exhaust gases from automobile engines and faulty heating apparatus.

This action of carbon monoxide is insidious because its effects occur so gradually. It has a stronger affinity for the hemoglobin in blood than has oxygen, so the oxygen is quickly displaced leaving the hemoglobin without power to carry the needed oxygen to the body tissues. This change comes about without being apparent. At first, a slight headache or muscular weakness may be noticeable, though the victim may not feel this until he starts to move or exercise, when he becomes helpless and falls. He soon becomes unconscious and death may follow rapidly.

The Closed Garages

Automotive engineers will agree that it is advantageous to allow an engine to become "warmed up" before driving in cold weather. But before stepping on the starter in the family garage, however, there is an even more important step for you to take. Open wide your garage doors to the outside air. By warming up the car you help protect its metal mechanism, but your own protection should come first. By opening your garage for ventilation, you protect your body mechanism by preventing dangerous accumulation of carbon monoxide gas. You do not provide proper ventilation unless the doors are left wide open during the entire period.

Defective Engine Exhaust System

It is safer when driving, with the engine of the car going, to leave at least one window slightly open, no matter how low the temperature outside. This prevents the accumulation of carbon monoxide present in the gases which may have seeped through the car because of some defect in the exhaust system. During a long trip, driver and passengers may suffer from the effects of small amounts of the gases. Symptoms such as headache, dizziness, or nausea may occur. If these symptoms develop, the car should be more thoroughly ventilated. Any order of exhaust gases noticed in the car while engine is running, is sufficient reason for having the exhaust system examined, and if necessary, overhauled.

Gas Hot Water Heaters

Improperly installed and poorly serviced gas water heaters are the cause of avoidable deaths each year. Gas burning water heaters and space heaters should always be vented to the outside air. Flues should be equipped with a draft hood, to prevent a sudden back draft extinguishing the flame. The automatic type of heater should be equipped with safety devices which will shut off the gas supply to the main burner in case the pilot is extinguished. On space heaters using liquified petroleum gases, these automatic pilots should also shut off the gas supply to the pilot burner.

Coal Burning Furnaces

Coal burning furnaces may also produce carbon monoxide. Installations should be inspected regularly to see that flue piping, chimneys or drafts are not defective. Time should always be allowed for the first gas to be vented after stoking, before dampers are closed, and there should be sufficient draft to carry off products of combustion.

First Aid Measures

If you should find a person overcome with carbon monoxide poisoning, throw doors and windows wide open and remove the patient to fresh air at once. Call a doctor and while awaiting his arrival, give artificial respiration continuously or until natural breathing is restored.
(The above article is from Connecticut State Department of Health, Weekly Health Bulletin, Oct 15, 1951)

IS CANCER RESEARCH GETTING ANYWHERE ?

By

WALTER C. ALVAREZ

Editor in Chief, "Modern Medicine", Oct. 15, 1951

Physicians sometimes wonder if the many men who are now seeking a cure for cancer are getting anywhere. Have they turned up any promising leads?

Yes, they have. But perhaps the biggest thing they have done is to work out methods for quickly learning if a newly synthesized drug has promise of being a cure.

In the old days when a supposed treatment for cancer had to be tested on men and women, a few years had to elapse before the drug could be pronounced useful or useless. Now the tests can be run on a few hundred mice with cancer and the answer be obtained in months. Still, this is not quick enough, because the chemists are now making new drugs faster than the biologists can test them.

Hence, as C.P. Rhoads of the great Memorial Hospital in New York recently wrote, two faster and better technics had to be worked out. In one, cancer cells are grown on chick embryos, and in the other they are grown in test tubes with normal cells. If a drug tested stops growth in the cancer cells without killing the chick embryo cells, or if it kills only the cancer cells in the test tube, it is worthy of further trial in animals.

Already a number of promising drugs have been found, and more substances related to them are constantly being synthesized and tested.

While some men are perfecting testing technics, others are doing everything possible to discover differences between the metabolic processes of cancer cells and normal body cells. If we knew enough about these differences it might be easy to find a drug which would stop the growth of the cancer cells without injuring the normal cells.

As Rhoads says, already decided differences have been found in the "appetites for food" of cancer cells and normal cells. These differences will help in the search for new drugs.

Stanley P. Reimann of Philadelphia recently wrote that a substance has been found that will always cure cancer in mice but it is so toxic that some of the mice die. Perhaps a related substance can now be found which will kill none.

For some time Reimann and his associates have been following a lead opened up years ago by Coley, a New York surgeon. Having been impressed by the fact that an attack of erysipelas sometimes would cure a person suffering from sarcoma, Coley injected such patients with a sterile culture of streptococci. He obtained a few cures but the treatment was very rough on the patients.

Recently the curative substance in Coley's fluid has been isolated and found to be polysaccharide. It causes hemorrhage and necrosis in sarcomas but is too toxic for comfortable use in the cases of men and women. It has been used in a few cases to shrink malignant tumors so that later a surgeon could more easily remove them. Perhaps soon a polysaccharide can be found which will be more effective and less toxic.

Colchicine is a promising drug for study because for a while it will stop mitosis in cells. Already 200 drugs related to colchicine have been synthesized. They are now being tested.

Other leads are being followed, and almost certainly some day the desired drug will be found. As Rhoads states, it is hopeful that new studies are showing that cancer cells act in the body somewhat as harmful bacteria do. Perhaps the antibiotic technics which now curb the activities of many bacteria will some day stop the growth of cancer cells.

One obstacle to progress is financial, as E. V. Cowdry in a masterly summation of the present-day situation in regard to cancer research points out. He feels that many places funds are inadequate and the laboratory workers live from year to year wondering if their grant will be renewed.

PREVENTIVE MEDICINE

RETURNING KOREA VETERANS TO RECEIVE NEW ANTIMALARIAL DRUG

All servicemen returning from Korea will receive a new antimalarial drug, primaquine. Major General George E. Armstrong, Army Surgeon General, reported that the decision was based on evidence that the drug is entirely safe in the 15 milligram dose, and will cure the Korean type of malaria in most instances.

The move has been endorsed by both the Sub-committee on Malaria of the National Research Council and the Armed Forces Medical Policy Council.

The new procedure will begin as soon as the drug can be made available in the Far East Command. Arrangements for its administration have been completed by the three services. The plan calls for personnel rotated from Korea to receive one dose of one gram of the malaria suppressant, chloroquine, followed by 15-milligram doses of primaquine for 14 consecutive days. Primaquine will also be used in combination with other antimalarial agents in the treatment of cases of acute malaria.

It was emphasized that although final results may seem similar, primaquine is not a preventive for malaria. Neither is it a substitute for chloroquine as a suppressant in malarious areas. Instead, it is an effective therapeutic agent against malaria when the parasites which cause the disease have lodged in the liver or other body organs. It is therefore expected that the serviceman who has been exposed to malaria will be cured before an attack of malaria or before relapses of the disease can occur.

Although field trials have been limited it seems probable that malaria incidence in returnees to the United States can be sharply reduced with primaquine. In addition, it should be possible to avoid relapses in cases where an acute attack has already taken place.

Experimentation with primaquine dates from the end of World War II when it was included among many thousands of drugs marked for testing as antimalarial agents. Primaquine was first synthesized in 1945 by Dr. Robert Elderfield of Columbia University, working under a grant from the Office of Scientific Research and Development. Commercial synthesis was first effected by Dr. Elderfield in March 1950 under a United States Public Health Service grant. Early toxicity and neuropathology studies on the drug were conducted in December 1947 by Dr. Leon Schmidt of the Institute for Medical Research, Christ Hospital, Cincinnati, also under Public Health Service auspices.

Early human toxicity studies and clinical investigations were begun in March 1948 among prisoner volunteers. It was these tests which first established that primaquine could be given in adequate dosages without side effects and that the drug appeared to have a remarkable efficacy in the radical cure of malaria. Investigators were particularly encouraged when it proved effective even against the stubborn Chesson strain of vivax malaria found in certain Southwest Pacific areas.

Testing among military personnel was begun to determine how effective the drug was in the treatment of the Korean strain of malaria and also, the possibility of undesirable side-effects when primaquine was administered to healthy men engaged in normal activities. The latter test was completely successful and showed no toxic effects when the drug was taken in the prescribed 15 mgm. doses. After periods up to 86 days there have been no recurrences among those receiving primaquine after developing acute malaria.

The final test was completed early this month, with the administering of the 14 day series to soldiers returning from Korea. During this study, it was found that no ill-effects resulted in giving the drug in regular doses aboard ship and, also that the administration of the series was practicable.

General Armstrong predicted that the program being put into operation would prove effective but emphasized that further research would be necessary to determine finally the dose needed for the most rapid cure. Investigation of the drug is continuing in a number of Army posts and under Public Health Service auspices.

(The above is an article from Department of the Army, Office of the Surgeon General, Technical Information Office, Washington 25, D. C.)

ADMINISTRATIVE SERVICE

IF WASHINGTON IS HIT BY A-BOMB FOOD SUPPLIERS ARE READY TO FEED SURVIVORS

Nobody really knows just what would happen if Uncle Joe dropped one of the 50 or more atomic bombs he's supposed to have on the nation's capital. But one thing is settled. As soon as the all-clear siren sounded, Washington's 100 food suppliers would lock their doors and await instructions from the Emergency Food Section of the District of Columbia Office of Civil Defense. At the same time, the capital's 1,000 restaurants and 33 hotels would also close.

Under plans now being formulated by Gardner Moore, manager of the Shoreham Hotel and chairman of the District's Civil Defense Food Committee, each food supplier and each restaurant owner would be the disaster feeding official in charge of his own establishment. Under attack, he simply changes his hat from business entrepreneur to government administrator.

If his facilities aren't needed, a food inspector will check his place to see that the food-stuffs are safe and give him permission to reopen for normal business. But if his facilities are needed, he'll proceed to pitch in and feed the homeless free of charge. He'd keep his own books and be reimbursed later under arrangements now being worked out.

According to D.C. Civil Defense estimates, one well-placed bomb might mean 200,000 hungry mouths to feed for several days: 32,000 defense workers would need coffee and sandwiches to keep them at their heartbreaking rescue job; 65,000 patients would have to be fed as well as treated in emergency hospitals; and 100,000 others would be homeless but able to walk to mass feeding centers for a meal.

Washington's food supply normally comes from Baltimore jobbers, but there's usually enough in the city to last the population for two weeks. That means that the city would carry on, perhaps on short rations, for a week or two even if one third of the wholesale houses were completely destroyed. Replenishments could come quickly from Virginia, West Virginia and the Carolinas, where there are 449 wholesale grocers, 23 warehouses of grocery chains, 260 bakeries, 11 major dairies, nearly 2,000 wholesale produce dealers and 250 meat packing plants. Under mutual aid agreements, these near-by sources could have trucks rolling toward Washington within a few hours.

Reliance on existing facilities and the existing food distribution system which has been built up over years of trial and error is safer and simpler than stockpiling foodstuffs, Mr. Moore feels, aside from the expense, wastage and storage space which would be required for a food stockpiling program. The food industry can do the job and should organize itself to do it, he thinks. In order to avoid panic and assure orderly distribution, all foodstuffs outside of private homes would be controlled by the Food Section, Grocery stores still operating might have to limit the size of order for a few days.

Defense workers would get snack type meals from a fleet of trucks carrying food from hotel and restaurant kitchens. Coffee would be distributed in vacuum containers and served in disposable paper cups, while sandwiches would be packaged in paper. In the beginning, paper goods for this purpose would be drawn from the stockpile recently set by the paper cup and food container industry.

Washington's Civil Defense organization is requesting \$60,000 for trucks similar to the Red Cross canteen trucks for the distribution of food to emergency food units. These trucks, which haven't been fully designed as yet, will be much larger than the Red Cross units and should be capable of carrying 5,000 sandwiches at a time with vacuum containers of coffee and perhaps small Coleman stoves which have their own fuel.

The feeding of hospital patients would, of course, have first priority both on foodstuffs and on the stocks of paper goods for emergency feeding. Over 30 public buildings, schools and churches have already been chosen as sites for emergency hospitals in the event of an atomic bomb. Some of these buildings already have cafeteria facilities which could be used for patient feeding, but some would have to be supplied with food from restaurant and hotel kitchens.

Hospital feeding plans, being perfected by the D.C. Dietetics Association, call for all paper service in all emergency units. Since the patient population of existing hospitals would in some cases be doubled by putting beds in halls, their food services would undoubtedly be overloaded. Paper service would be essential. Bulk service from wards, cafeteria service for ambulatory patients

ADMINISTRATIVE SERVICE

and other shortcuts are being studied by Georgia Smith and her committee of hospital dietitians.

Medical and Health officers of the District's Civil Defense organization are planning to reach the injured with 60 mobile medical trailers, each of which would be a little hospital on wheels. They have asked for 30 of these trailers in the budget now being considered by the D.C. Committee of the House. Plans for the trailers aren't perfected yet, but the District Medical Society has presented a model trailer to the civil defense organization.

This model trailer, constructed by the Emergency Equipment Company, manufacturers of iron lungs, carries pharmaceuticals, blood plasma, facilities for administering oxygen to 100 patients at once, 4 emergency folding operating tables, and a stove for heating so that instant hot coffee or tea can be given to shock victims. Hot drink paper cups in long dispensers are attached to the back door of the trailer for handy use. The Trailer, which closes completely to 6 1/2 x 10 x 7 feet, can be drawn by any automobile and is expected to cost from \$2,500 to \$3,000.

When fully developed, the District defense plan will rely largely on volunteers. The organization hopes that its fall recruiting campaign will attract 100,000 volunteers, 65,000 of whom will serve as air raid wardens. The disaster food services will need 10,000 volunteers, most of whom Mr. Moore thinks he can draw from restaurant and hotel employees who wouldn't require extensive training. However, he already has 50 volunteers who are taking disaster food service training provided by the Red Cross.

(The above article from "Single Service News", October-November, 1951)

* * *

ARMY RETURNS HANDICAPPED VETERANS TO FULL DUTY POSITIONS

More than 1,500 handicapped veterans of World War II and the fighting in Korea have been returned to full duty positions since November, 1946.

Amputees and other disabled personnel who have been rehabilitated and reassigned to full-time Army jobs in the United States and overseas include staff officers, administrators, combat training instructors, engineers, postal clerks, typists, finance officers, intelligence experts, small arms repairman and a host of other critically needed specialists.

"You forget these men are wearing artificial limbs," according to Colonel Maurice J. Fletcher, director of Army Prosthetics Research. "They are perfectly capable of doing almost any job. The rarity is to find a job which they can't do. One inescapable conclusion drawn from the rehabilitation program of the Army Medical Service is that no new, 'soft' jobs need be created for men who have suffered physical impairment in combat."

For many veterans of the Korean fighting, who lost a leg, disability has meant taking up a challenging new specialty. A former Infantry Lieutenant now attending Army Finance School is slated for a full duty assignment in his new branch.

For others, amputations have caused no change in career plans. A soldier who now wears an artificial hand has been reinstated to full duty as an Army machine shop mechanic -- the same work he did as a civilian. Another, an expert in cryptography, who lost a leg, works in the coding room at Fort Benning, Georgia.

At the Prosthetics Laboratory at Walter Reed Army Medical Center in Washington, D. C., there are many amputees, who have chosen to work with others of their kind in testing prosthetic devices. One is again working as an engineer, another, a hand amputee, is supply and property officer at the laboratory.

Hundreds of amputees are again on full duty overseas assignments despite disability. The only limitation placed on duty assignments involve extended field tours requiring prolonged walking. Most are confident they could handle combat staff jobs with ease.

(The above is from Department of Defense, Off. of the Surgeon Gen, Technical Information Office, Washington 25, D.C.)

ADMINISTRATIVE SERVICE

ACCESS TO AND RELEASE OF INFORMATION FROM ARMY RECORDS TO THE PUBLIC (AN EXCERPT FROM AR 345-20, DATED 9 MARCH 1951)

Section II. Par 10c: "Upon receipt of requests therefor by individuals, including those in the executive branch of the Government who are not entitled thereto by virtue of their official duties, private companies or organizations, or agencies of State or local governments, properly and directly concerned, The Surgeon General and the commanding officer of any medical treatment facility, respectively, are authorized, subject to the restrictions set forth in paragraph 16b, to furnish access to unclassified papers within the categories covered by paragraph 16a (5) to (8), inclusive, except those which involve former members of the military service and those which, in special instances, are held to be confidential for good cause by the officer acting on the request."

Section III. Par 16a: "Set forth below are findings that certain individuals, private companies or organizations, or agencies of State or local governments are properly and directly concerned with described categories of papers. The Surgeon General or the commanding officer of any medical treatment facility may, to the extent that authority therefor is delegated by paragraph 10c and subject to the restrictions set forth in b, below, furnish access to or information from unclassified papers within any of the categories set forth in (5) to (8) below, inclusive, to the parties indicated in the respective findings.

- (5) Medical records relating to a member of the military service or a civilian employee, including any such former member or civilian employee, or to any other person who was a patient in a medical treatment facility of the Army Establishment are the proper and direct concern of the individual to whom they pertain and, in the event he has been adjudged insane or is dead, the next of kin and legal representative. Information therefrom and copies thereof may be furnished to the individual to whom they pertain; provided, that no information which might prove injurious to his physical or mental health will be released to him; and, in the event the information would be injurious to his physical or mental health or he has been adjudged insane or is dead, to next of kin and legal representative.
- (6) Medical records pertaining to an individual within a class described in (5) above are the proper and direct concern of, and information therefrom or copies thereof may be furnished with the consent of the individual concerned or his legal representative to, a registered civilian physician when required in connection with medical treatment of that individual.
- (7) Medical records pertaining to an individual within a class described in (5) above are the proper and direct concern of, and information therefrom or copies thereof may be furnished to, a Federal or State hospital or penal institution when the individual to whom they pertain is a patient or inmate therein.
- (8) Information from or copies of medical records may be furnished to duly accredited representatives of the National Academy of Sciences-- National Research Council, when engaged in cooperative studies undertaken at the specific request of or with the consent of The Surgeon General."

* * * * *

BRIEFLY

Dependent travel to Japan will be resumed this month.....first time since July '50.....still on limited basis only.....

First 2 volumes of 6 on Character Guidance are released.....under general title "Duty, Honor, Country".....supervised by Chaplains.....

New SR on prices for initial issue EM clothing is published.....Change 2, SR 32-20-2.....

All commanders again urged to support Defense Bond Drive.....see DA Circular 79.....

The 1952 All-Army Track and Field Meet to open about 1 June '52.....tryouts for Olympics.. see DA Circular 78 for details.....

ADMINISTRATIVE SERVICE

ALPHABETICAL INDEX TO MEDICAL TECHNICAL BULLETINS. WITH CROSS-REFERENCES

We present below a complete index to all current Medical Technical Bulletins, more familiarly known as "TB Meds". For ease of reference, all titles have been cross-indexed.

These publications have consistently presented, for the benefit of all members of the Medical Service the latest thinking, up-to-date studies and reports on new techniques and procedures to aid the military medical man in the performance of his varied duties.

With the exception of the group giving Medical and Sanitary Data on various geographical areas of the world, these bulletins have been revised as required, to keep pace with new developments. It was originally the intent to complete the Medical and Sanitary Data series, and concurrently bring the earlier issues up-to-date, but this program has been curtailed by the imposition of personnel ceilings, and many of the earlier TB Meds in this series, prepared hastily during World War II without complete corroboration of data, require considerable revision. It is to be hoped that this program will be renewed in the near future.

ALPHABETICAL INDEX TO MEDICAL TECHNICAL BULLETINS, WITH CROSS-REFERENCES

	TB MED NO.
Active Tuberculosis, Diagnosis of ---	221
Admission, Indicating Place of, on WD MD Forms No. 52	7
Aegean Islands, Medical and Sanitary data on ---	26
Aircraft, Spraying of DDT from ---	200
Albania, Medical & Sanitary data on ---	40
Algeria, Medical & Sanitary data on ---	90
Allergy	202
Amebiasis and Schistosomiasis, Water Treatment in areas where --- are hazards	190
Amebiasis	159
Andaman and Nicobar Islands Medical and Sanitary data on ---	105
Anesthesia (Local Anesthetic Agent)	43
Anesthesia, Resuscitation and Early Care of Wounded, Use of Morphine	234
Animals, military, control of ringworm in --	161
Aphasic Language Disorders	155
Asphyxia, Treatment of Respiratory depression and --	131
Austria, Medical and Sanitary data on ---	59
Azores, Medical and Sanitary data on the ---	123
Bacillary Dysentery	119
Bacteriological culture media, use of para-aminobenzoic acid in ---	60
Balearic Islands, Medical and Sanitary data on ---	185
Banda Sea, Medical and Sanitary data on Islands in the Eastern Port of the ---	70
Battle Casualties, Management of ---	147
Belgium, Medical and Sanitary data on ---	36
B Encephalitis, Japanese	181
Blister Gas Contamination of the Eye, First Aid for liquid ---	153
Blood Transfusion, complications of	204
Borneo, Medical and Sanitary data on ---	113
British Malaya, Medical and Sanitary data on ---	95
British Somaliland, Medical and Sanitary data on ---	130
Bulgaria, Medical and Sanitary data on ---	58
Burma, Medical and Sanitary data on ---	77
Burns, Thermal, Surgical Management of ---	151
Canary Islands, Medical and Sanitary data on ---	192
Caroline Islands, Medical and Sanitary data on the ---	50
Casualties, battle, management of ---	147
Celebes, Medical and Sanitary data on ---	67
Central Dental Laboratory Service	148

ADMINISTRATIVE SERVICE

	TB MED NO.
Ceylon, Medical and Sanitary data on ---	109
Chest diseases, Notes on certain ---	69
China, Northeastern, Medical and Sanitary data on ---	220
China, Southeastern, Medical and Sanitary data on ---	171
Cholera	138
Clinical Psychological Service in Army Hospitals	115
Clothing Impregnating Plant M-1 (Theater of operations)	213
Complications of Blood Transfusion	204
Consultation Service	156
Control of Diseases of Respiratory System and other diseases transmitted by discharge from respiratory tract	47
Control of Ringworm in Military Animals	161
Convalescent Care and Rehabilitation of Patients with Spinal Cord Injuries	162
Convalescent Treatment Program for Neuropsychiatric patients	80
Corrective lenses, Mounting in Welder's goggles --	91
Corsica, Medical and Sanitary data on ---	125
Crete, Medical and Sanitary data on ---	61
Cutaneous Diphtheria	143
Czechoslovakia, Medical and Sanitary data on ---	107
Danzig, Medical and Sanitary data on ---	176
DDT, Spraying of, from aircraft	200
Denmark, Medical and Sanitary data on ---	52
Dental Laboratory Service (central)	148
Diabetes Mellitus	168
Diagnoses, Nomenclature and Method of Recording	203
Diagnosis of Active Tuberculosis	221
Diagnostic techniques, neurological ---	76
Diphtheria, cutaneous	143
Disinfestation Procedures	184
Dodecanese Islands, Medical and Sanitary data on ---	93
Drug Suppressive Treatment of Malaria	65
Dutch New Guinea, Medical and Sanitary Data on ---	18
Dysentery, bacillary	119
Electrical requirements for X-Ray apparatus in the field or in temporary installations	117
Electroencephalography: Operative technique and interpretation ---	74
Emergency Feeding of Infants, Children, and other special groups of civil populations	53
Epidemic (Louse-Borne) Typhus	218
Equipment and Supply for Storage, Preservation of Medical Service ---	235
Excessive X-radiation exposures during Roentgenography & Roentgenoscopy	62
Eye, First Aid for Liquid Blister Gas Contamination of the ---	153
Facilities Provided for Tissue Pathology in US Army ---	19
Filariasis (Wuchereria) with special reference to early stages	142
Film programs for educational reconditioning in ASF hospitals	145
Films for reconditioning for bed and ward patients in ASF hospitals	166
Finland, Medical and Sanitary data on ---	66
First Aid for Liquid Blister Gas Contamination of the Eye	153
Food Analysis, Veterinary Laboratory Service	233
Formosa, Medical and Sanitary data on ---	30
Fractures, reduction of, during fluoroscopic exposure	22
Fractures, Suspension - Traction Treatment of ---	133
French Indo-China, Medical and Sanitary Data on ---	86
Function and scope of Medical Department Laboratories	135
Gas Mask, technique for applying, to a helpless patient	169
Germany, Medical and Sanitary data on ---	27
Gilbert & Ellice Islands, Ocean Island, and Nawn, Medical and Sanitary data on ---	189

ADMINISTRATIVE SERVICE

	TB MED NO.
Gold Coast, Medical and Sanitary data on the ---	129
Group Psychotherapy ---	103
Guam, Medical and Sanitary data on ---	57
Hainan, Medical and Sanitary data on ---	118
Health Hazards from Industrial Solvents	35
Heat, Adverse effects of, prevention and treatment of ---	175
Hepatitis, infectious	206
Hungary, Medical and Sanitary data on ---	140
Immunization	114
India, Medical and Sanitary data on ---	174
Indications and Contraindications for Keratoplasty and Keratectomies	177
Indo-China, French, Medical and Sanitary Data on ---	86
Induction Station Neuropsychiatric Examination	33
Industrial Solvents, Health Hazards from ---	35
Infectious hepatitis	206
Instructions for operating Kit, Water Testing, Poisons, Treatment Control	37
Italian Somaliland, Medical and Sanitary Data on ---	132
Italy, Medical and Sanitary data on ---	178
Irkutsk and Chita Oblasts, and the Uakut and Borgat-Mongolian Autonomous Republico, Medical and Sanitary data on	209
Izu, Bonin, Kazan, and Marcus Islands, Medical and Sanitary data on ---	83
Japan, Medical and Sanitary data on ---	160
Japanese B Encephalitis	181
Java, Medical and Sanitary data on ---	102
Kamchatka, Medical and Sanitary data on ---	46
Keratoplasty and Keratectomies, Indications and Contraindications for --	177
Khabarovsk Krai and Maritime Krai (Far Eastern Territory) USSR, Medical and Sanitary data on ---	88
Korea, Medical and Sanitary data on ---	208
Kurile Islands, Medical and Sanitary Data on ---	24
Laboratories, Function and scope of Medical Department	135
Language Disorders, Aphasic ---	155
Lecture outlines for enlisted men on personal adjustment problems	21
Lecture outlines for officers on personnel adjustment problems	12
Leprosy	205
Lesser Sunda and Southwestern Islands, Medical and Sanitary data on ---	75
Levant States (Greater Syria), Medical and Sanitary data on the ---	128
Life of Photoroentgen films	99
Local Anesthetic Agent	43
Malaria Control in the Army	164
Malaria, Drug Suppressive Treatment of ---	65
Malaria, Treatment of clinical, and malarial parasitemia	72
Malaya, Medical and Sanitary data on British ---	95
Management of Battle Casualties	147
Management of Syphilis	198
Management of Venereal Diseases	230
Mariana Islands, Medical and Sanitary Data on ---	20
Marshall Islands, Medical and Sanitary data on the ---	111
Medical Nutrition Examination	224
Medical Problems of Redeployment	170
Menopause	158
Moistureproofing and fungiproofing (Tropicalizing) Medical Department equipment	186

ADMINISTRATIVE SERVICE

	TB MED NO.
Molukken Islands and Islands in the Eastern Part of the Banda Sea, Medical and Sanitary data on ---	70
Morphine, Use of, in anesthesia and resuscitation	234
Mounting Corrective Lenses in Welder's Goggles	91
Mozambique, Medical and Sanitary data on ---	179
Music in Reconditioning in ASF Convalescent and General Hospitals	187
Needles and Syringes, Use of ---	78
Netherlands, Medical and Sanitary data on the ---	39
Neurological Diagnostic Techniques	76
Neuropsychiatric Examination, Induction Station	33
Neuropsychiatric Examination, WAC Recruiting Station	100
Neuropsychiatric Patients, Convalescent Treatment Program for ---	80
Neuropsychiatry for General Medical officer	94
Neurotropic Virus Diseases	212
Nomenclature and Method of Recording Diagnoses	203
Northeastern China, Medical and Sanitary data on ---	220
Norway, Medical and Sanitary data on ---	29
Notes on Certain Diseases of the Chest	69
Nutrition Examination, Medical	224
Nutritional Value and Characteristics of certain expeditionary and packaged rations	141
Orthopedic and Amputation Cases, Coordination of Physical and Surgical Therapy of---	10
Ostrova Komandorskiye, Medical and Sanitary data on ---	139
Oxygen Therapy Apparatus Closed Circuit: Boothby-Lovelace	1
Palau Islands, Medical and Sanitary data on the ---	41
Palestine and Trans-Jordan, Medical and Sanitary data on ---	126
Poracel Islands, Medical and Sanitary data on---	152
Philippine Islands, Medical and Sanitary data on ---	68
Phlebotomus (Sand-fly) fever ---	82
Photocentgen films, life of ---	99
Physical and Educational Program for Tuberculosis Patients in Army Hospitals	222
Physical and Surgical Therapy of orthopedic and amputation cases, coordination of ---	10
Physical Reconditioning for Bed and Ward Patients	137
Pilonidal Cyst and Sinus	89
Plague	124
Poisons, Instructions for operating Kit, Water Testing, Treatment Control	37
Poland and Danzig, Medical and Sanitary data on ---	176
Poliomyelitis	193
Portugal, Medical and Sanitary data on ---	56
Pratas Island, Medical and Sanitary data on ---	146
Preparation of Part IX, Communicable Diseases, of WD MD Form 86ab	92
Preservation of Medical Service Equipment and Supplies for Storage	235
Prevention and Treatment of Adverse effect of heat	175
Professional Rounds and Meetings in Hospitals	210
Protective devices, respiratory ---	223
Psychiatric Patients, Treatment program for, in Station and General Hospitals ---	84
Psychological Service, Clinical, in Army Hospitals	115
Psychotherapy, Group ---	103
Pulmonary Tuberculosis, Rest Regimen in the management of ---	236
Reconditioning, education film programs for -- in ASF hospitals	145
Reconditioning for bed and ward patients in ASF hospitals, films for ---	166
Reconditioning, music in, in ASF Convalescent and general hospitals	187
Reconditioning, physical, for bed and ward patients	137
Reduction of fractures during fluoroscopic exposure	22
Respiratory depression and Asphyxia, Treatment of ---	131

ADMINISTRATIVE SERVICE

	TB MED NO.
Respiratory protective devices	223
Respiratory system, Control of diseases of ---	47
Rest Regimen --- in the management of pulmonary tuberculosis ---	236
Resuscitation and early care of the wounded	234
Rheumatic fever	97
Ringworm in Military Animals, Control of ---	161
Rumania, Medical and Sanitary data on ---	49
Ryukyn Islands, Medical and Sanitary data on ---	108
 Sakhalin, Medical and Sanitary data on ---	150
Sand-Fly (appataci, Phlebotomus) Fever	82
Sanitary Control of Army Swimming Pools and Swimming Areas	163
Sanitary Control of Water Supplies for fixed installations	229
Schistosomiasis Japonica	167
Scrub Typhus Fever (Mite-borne Typhus, Tsutsugamushi Disease)	31
Silver or silver nitrate stains ---	228
Solvents, Health Hazards for Industrial ---	35
Somaliland, Italian, Medical and Sanitary data on ---	132
Southern China, Medical and Sanitary data on ---	171
Spain (Exclusive of the Balearic and Canary Islands), Medical and Sanitary data on ---	165
Spinal Cord Injuries, patients with, Convalescent care and rehabilitation of ---	162
Spraying of DDT from Aircraft	200
Sulfonamide drugs, Treatment of infectious diseases with ---	172
Sumatra, Medical and Sanitary data on ---	120
Supplies, Preservation of Medical Service Equipment and, for Storage	235
Surgical Management of thermal burns	151
Suspension - Traction Treatment of Fractures	133
Sweden, Medical and Sanitary data on ---	54
Swimming Pools and Swimming Areas, Sanitary Control of ---	163
Switzerland, Medical and Sanitary data on ---	55
Syphilis Management of ---	198
Syria (Greater), Medical and Sanitary data on ---	128
Syringes, Use of needles and ---	78
 Technique for applying gas mask to a helpless patient	169
Thailand, Medical and Sanitary data on ---	63
Thermal Burns, Surgical management of ---	151
Tissue Pathology, Facilities provided for --- in US Army	19
Transfusion, blood, complications of ---	204
Trans-Jordan, Medical and Sanitary data on	126
Transportation and Storage of Unexposed sensitized materials	191
Treatment of Clinical Malaria and Malarial Parasitemia	72
Treatment of Infectious diseases with sulfonamide drugs	172
Treatment of Respiratory Depression and Asphyxia	131
Treatment Program for Psychiatric Patients in Station and General Hospitals ---	84
Trench Foot	81
Trichomonas Vaginalis Vaginitis	8
Tsutsugamushi Disease	31
Tuberculosis Active, Diagnosis of ---	221
Tuberculosis Patients, Physical and Educational Program for, in Army Hospitals	222
Tuberculosis Pleurisy with Effusion ---	71
Tunisia, Medical and Sanitary data on ---	98
Turkey, Medical and Sanitary data on ---	64
Typhus, Epidemic (Louse-borne)	218
Typhus (Scrub typhus fever)	31
 Uganda, Medical and Sanitary data on ---	197

ADMINISTRATIVE SERVICE

	TB MED NO.
Use of BAL in oil and BAL ointment in treatment of Systemic poisoning caused by Lewisite and other Arsenical blister gases	101
Use of BAL in oil for treatment of certain severe Mapharsen Reactions	104
Use of Needles and Syringes	78
Use of Para-aminobenzoic acid in bacteriological culture media	60
Use of Projector AN/TFQ-5 for implementing film program outlined in TB Med 166	188
Use of War Wound Moulages in Teaching Emergency Medical Care and First Aid	116
 Venereal Diseases, Management of ---	 230
Veterinary Laboratory Service (Food Analysis)	233
Virus diseases, Neurotropic	212
Visceral Leishmaniasis - Kala-Azar	183
 WAC Recruiting Station Neuropsychiatric Examination	 100
War Wound Moulages, Use of, in teaching Emergency Medical Care and First Aid	116
Water Supplies, Sanitary Control of, for fixed installations	229
Water Treatment in Areas where Amebiasis and schistosomiasis are hazards	190
Welder's Goggles, Mounting Corrective Lenses in ---	91
 X-radiation, excessive, during Roentgenography and Roentgenoscopy	 62
X-Ray apparatus, electrical requirements for, in the field or in temporary installations	117
 Yakut and Buryat-Mongolian Autonomous Republico, Medical and Sanitary data on ---	 209
Yugoslavia, Medical and Sanitary data on ---	73

* * *

A PARTIAL EXPLANATION OF CODES USED IN EVALUATION OF RESERVES

Without being a medical discussion, here is at least part of the answer to questions about what, for example, "Code 3" means in the evaluation program.

Human functions have been considered in six factors. For ease in accomplishing and applying a profile system, these factors are designated as "PULHES." The term means: "P" physical capacity; "U" upper extremities; "L" lower extremities; "H" hearing; "E" eyes; and "S" neuropsychiatric.

There are four grades in each factor: 1, 2, 3, and 4. Generally speaking, the first three are considered acceptable, and 4 represent defects below minimum standards. Grade 1 is "perfect."

After a physical examination an individual receives a profile serial of six numerals. For further ease in assignment a letter code is established as follows: "A" an individual with a profile code 111111; "B" an individual whose profile serial has the numeral 2 as the lowest grade in any factor; "C" an individual whose profile serial has the numeral 3 as the lowest grade; "E" (there is no "D") an individual with the numeral 4 as the lowest.

Within the ORC there is a physical status factor used in part to determine mobilization availability. This code, and the answer to your questions, is this:

"1" corresponds to "A" above; "2" corresponds to "B"; "3" corresponds to "C"; "4R" means physical defects remedial within one year; and "4" corresponds to "E" above-physically disqualified.

See AR 40-115 and SR 140-133-1 for more detail.

(The above article is from "Report to the Army", November 1951)

ADMINISTRATIVE SERVICE

Whether you are a pessimist or an optimist seems to depend on when you were weaned, a London psychiatrist believes.

Dr. Frieda Goldman-Eisler said a three-year study of 115 cases showed that abrupt weaning at about three months of age arouses a sense of fear and resentment in the infant mind which persists in later life.

But these pessimists, she said, appear to be better money makers when they grow up than optimists--those weaned at leisure after the age of three months.

Altho 70 per cent of the optimists were in financial difficulties, she added, they generally live longer than pessimists.

VETERINARY SERVICE

TRICHINOSIS

Trichinosis is a parasitic disease caused by the *Trichinella spiralis*, a small nematode. The male is from 1.4 to 1.6 millimeters long and the female from 3 to 4 millimeters long. It is worldwide in distribution and occurs in carnivorous and omnivorous animals and is usually transmitted to man through the ingestion of the flesh of these animals.

Upon the ingestion of meat containing the encysted trichinella larvae, the larvae are digested from their cysts in the stomach and develop to sexually mature worms in the intestinal tract. The males die shortly after impregnating the female and are digested and discharged in the feces. After fertilization the females penetrate into the intestinal mucosa and deposit larvae which are carried by the lymph and blood to the voluntary muscles, especially those of the diaphragm, tongue, larynx, eye and the masticatory and intercostal muscles where they grow rapidly and lie curled up in small cysts which are fully formed after about three months. In this encysted form they may remain viable for several years. In animals these encysted larvae constitute the source of infection for the next host.

Scientists have known since 1860 that trichinosis was spread to man by eating pork from hogs infected with the encysted larvae of this tiny worm.

Many people believe that the federal stamp on pork assures freedom from trichinosis. This is a false sense of security in so far as trichinosis is concerned since microscopic examination of every bit of pork would be impractical, if not physically impossible. Federal regulations do require, however, that the preparation of ready-to-eat meats in packing houses under the supervision of the Bureau of Animal Industry (Meat Inspection Division) such products be heated to an internal temperature of at least 137° F. Therefore, ready-to-eat pork products bearing the federal stamp can be considered safe from trichinosis organisms.

Research has shown that if pork is stored at very low temperatures the trichinae are killed. At 5° F. a period of twenty days is required if the product is in separate pieces not exceeding six inches in thickness or arranged on separate racks with layers not exceeding six inches in depth.

The best way to stop cases of trichinosis is to cook thoroughly all pork and pork products before eating them. In roasting fresh or smoked pork, a meat thermometer is the best way to tell when the meat is done. It should be inserted in the thickest part of the meat without touching bone or fat. The meat is then roasted at 325° F. until the thermometer reads 185° F. for fresh pork and 170° F. for hams or 160° F. for precooked hams.

If no meat thermometer is available, fresh pork should be cooked at 325° F. until it becomes white and is not longer pink or red in the center, allowing at least 35 to 40 minutes to the pound. When roasting smoked hams, allow 15 to 20 minutes per pound for whole hams, 25 minutes per pound for half hams and 28 to 35 minutes for smoked shoulder cuts.

Smoked pork cuts such as slices of ham, bacon and sliced Canadian style bacon may be broiled or panbroiled. Pork chops and steaks are cooked best by braising. Allow 45 to 60 minutes to cook these, depending upon thickness. The same rule of cooking until well done should be followed when cooking pork liver and other products such as sausage, or meat loaf made with pork.

GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 21).

The non-effective rate* increased from the September rate of 16.26 to 16.62 for the month of October. Days lost as a result of disease and injury totaled 16,721 during the five week period ending 31 October 1951.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days} \times \text{Average Daily Strength}}$
in Period

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in October was 404.6, compared to 444.8 during September. Total admissions for disease and injury in October was 1115. Of this number 960 admissions were for disease and 155 injuries. Fort Myer reported the highest admission rate, and All Others reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

September's rate for disease cases is 348.3 for 960 cases. Fort Myer reported the highest admission rate, and Fort McNair reported the lowest rate for disease cases.

An injury admission rate of 56.2 per 1,000 per annum for October was reported. This was a decrease from the September rate of 71.8. Fort Myer reported the highest rate and All Others reported the lowest rate for injuries.

There were 2 deaths reported during the five week period ending 31 October 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of October 1951. The rate for the present month is 108.1 compared to the September rate of 109.0. Fort Myer reported the highest rate, and All Others reported the lowest rate. Admission rates for pneumonia (all types) increased during the October report period. The rate being 5.8 compared with the September rate of 5.3. There was one case of scarlet fever reported through the month of October.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the five week period ending 31 October 1951.

Pertinent statistical tables may be found on pages 22 and 26.

PREVENTIVE MEDICINE

RESTRICTED
SECURITY INFORMATION

GENERAL DATA

5-Week Period Ending 31 October 1951
(Data from DD Forms 442)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-	Number
	Total	White	Negro	All Causes		Disease		Injuries		Effective	of
				Cases	Rates	Cases	Rates	Cases	Rates	Rate	Deaths
Fort Belvoir, Virginia	17221	15164	2057	729	441.44	618	374.22	111	67.22	17.51	2
Fort McNair, Wash, DC	904	828	76	26	299.92	21	242.24	5	57.68	9.04	0
Fort Myer, Virginia	3841	3684	157	185	502.26	160	434.39	25	67.87	12.94	0
US Army Dispensary The Pentagon	3970	3952	18	105	275.80	94	246.91	11	28.89	22.10	0
All Others	2801	2795	6	70	260.61	67	249.44	3	11.17	10.91	0
Total - Military Dist. of Washington	28737	26423	2414	1115	404.61	960	348.36	155	56.25	16.62	
AMC - Med. Detach. (Duty Pers)	1617	1497	120	78	503.00	72	464.30	6	38.70	22.50	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
5-Week Period Ending 31 October 1951
(Data from DD Form 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Va.	112.63	8.48	6.06	-	1.21	.61	.61	-	1.21	-	-	12.11
Fort McNair, Wash, DC	69.21	-	-	-	-	-	-	-	-	-	-	-
Fort Myer, Virginia	138.46	2.71	2.71	-	-	-	-	-	-	-	-	5.43
US Army Dispensary The Pentagon	107.69	2.63	2.63	-	-	-	2.63	-	-	-	-	-
All Others	52.12	-	-	-	-	-	-	-	-	-	-	-
Total-Military District of Washington	108.14	5.81	4.35	-	.73	.36	.73	-	.73	-	-	7.98
AMC-Medical Detachment (Duty Personnel)	161.20	-	-	-	-	-	-	-	-	-	32.20	-

*

*

*

CONTROL OF ADULT MOSQUITOES IN ALASKA WITH AERIAL SPRAYS

At Eielson Field, Alaska, largescale spray tests with DDT for the control of mosquito larvae showed that adult mosquitoes infiltrated into an area of 100 sq. mi. within 3 days after they emerged from adjacent untreated areas. When this same area was sprayed to control adult mosquitoes, infiltration in about 2 weeks. In the tundra area at Umiat, Alaska, mosquitoes infiltrated into a 16-sq.-mi. area within 13 hours. Formulation studies indicated that a 20% DDT airplane spray could be improved by the use of spreaders or emulsifiers. The tests confirmed that 0.1 of DDT is a practical dosage and that nothing is to be gained by diluting the 20% spray to 5%. -- F. S. Blanton, B. V. Travis, N. Smith, & C. N. Husman. Jour. Econ. Ent., 43, 347-350 (1950). (BA Apr. 1951.)

*

*

*

"The strength and safety of America has principally rested on its citizen soldiers. Today we owe an enormous debt of gratitude to the many reserves who have met the attack in Korea and particularly to those who have taken up arms again for the second time in a generation. Their performance, in the face of sacrifice and hardship, has been an inspiration to all of us." Secretary of Defense Robert A. Lovett.

RESTRICTED
SECURITY INFORMATION

PREVENTIVE MEDICINE

VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, increased during the October report period.

The rate for October 1951, was 18.51, an increase over the September rate of 14.37. A total of 51 cases were reported for the five week period ending 31 October 1951. Of this total 42 were reported by Fort Belvoir, 5 cases for Fort McNair and 4 cases for Fort Myer.

During the report period, white personnel incurred 16 of the reported number of cases, with a rate of 6.31 and 35 were incurred by Negro personnel with a resulting rate of 157.73 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (October) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 23 and 24.

NEW VENEREAL DISEASE CASES - EXCL EPTS - AUGUST, SEPTEMBER AND OCTOBER 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	AUGUST 1951	SEPTEMBER 1951	OCTOBER 1951	OCTOBER 1951
Fort Belvoir	24.69	18.09	25.43	2.438
Fort McNair	23.94	-	57.68	5.530
Fort Myer	5.12	23.26	10.86	1.041
US Army Dispensary, Pentagon	-	-	-	-
All Others	-	4.47	-	-
Total - Military District of Washington Units	16.31	14.37	18.51	1.774
Army Medical Center - Medical and Holding Detachments	25.66	12.27	13.07	1.253
Total - Dept/Army Units Military Dist/Wash	17.24	14.06	18.02	1.739

* * * * *

QUOTE OF THE WEEK - From Army Information Digest - October 1951

"Regard your soldiers as your children and they will follow you into the deepest valley; look on them as your own beloved sons and they will stand by you even unto death. If, however, you are indulgent, but unable to make your authority felt; kindhearted, but unable to enforce your commands; and incapable, moreover, of quelling disorder; then your soldiers must be likened to spoilt children; they are useless for any practical purpose."

Sun Tsu on "The Art of War", about 500 B.C.

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY MDW RATE PER 1000 TROOPS PER YEAR

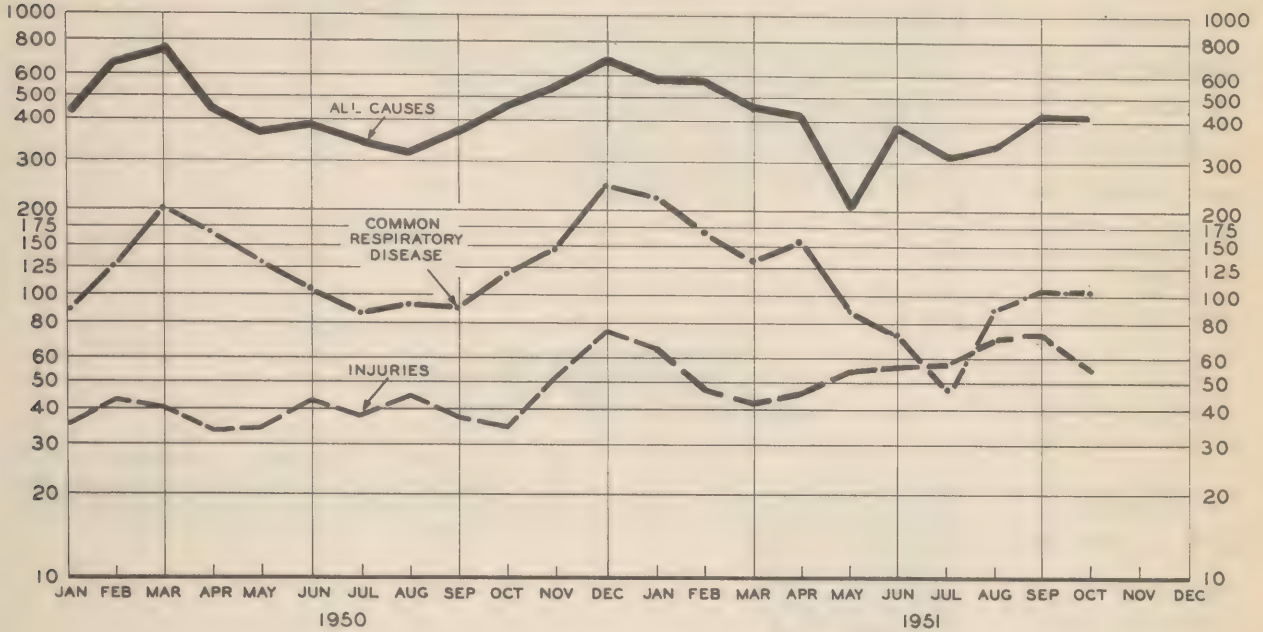
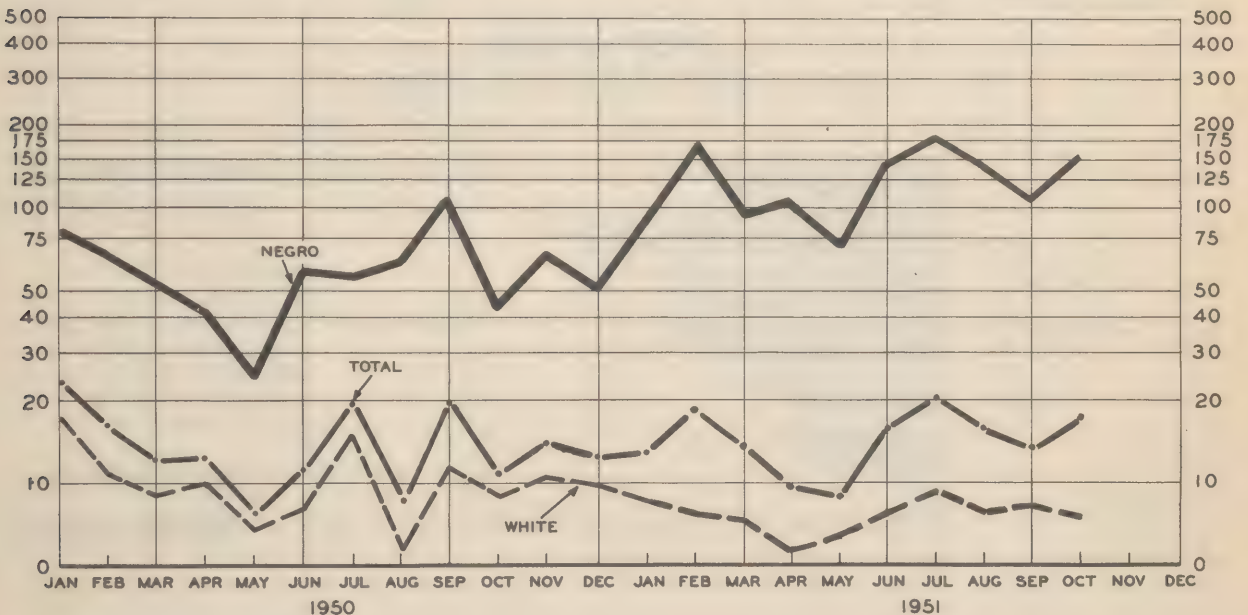


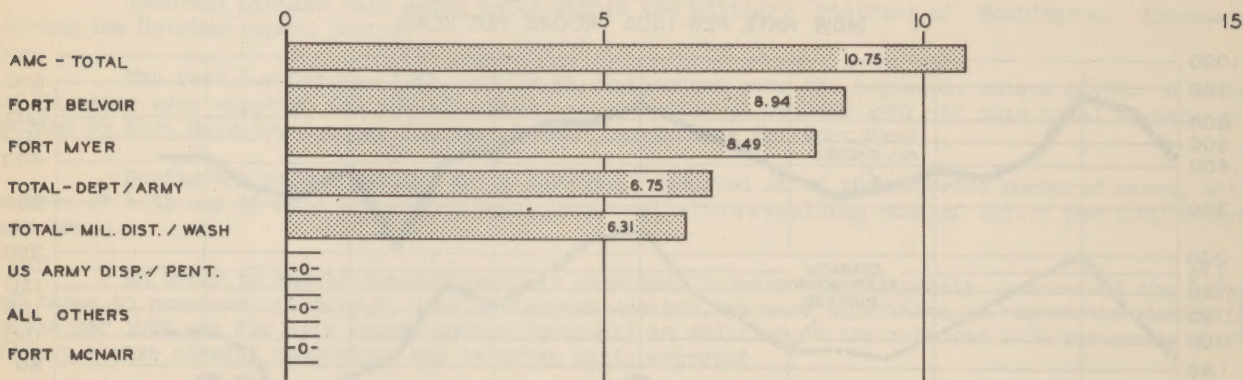
CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER RATES PER 1000 TROOPS PER YEAR INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS

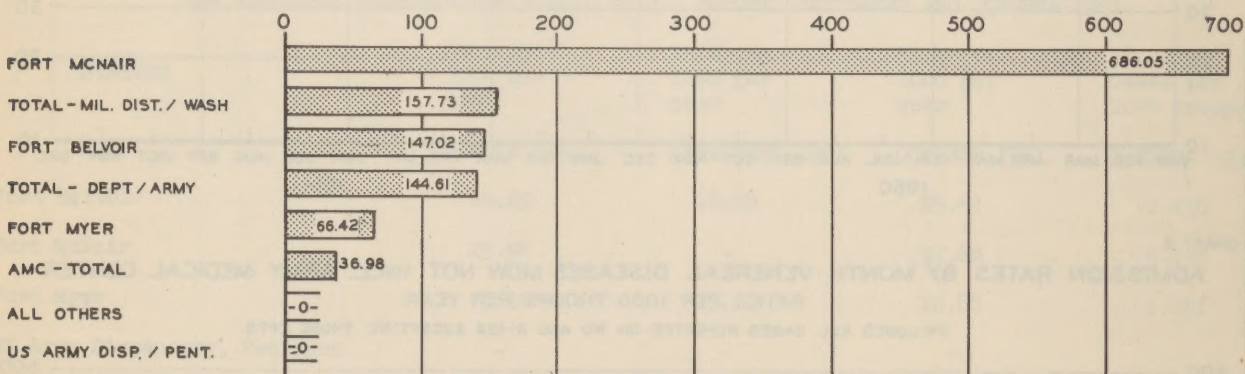


PREVENTIVE MEDICINE

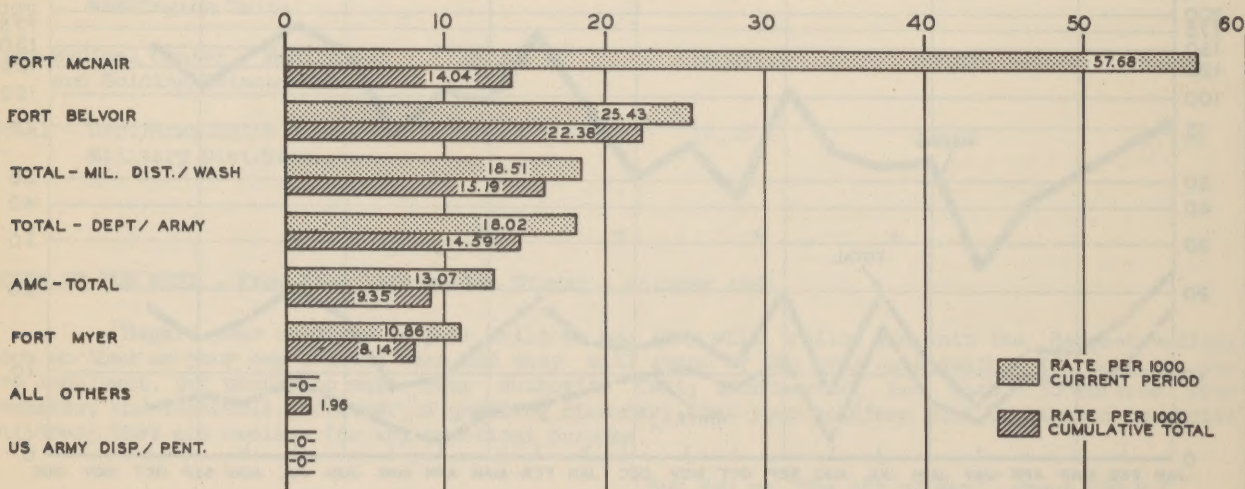
VENEREAL DISEASE
RATE PER 1000 TROOPS PER YEAR
5 WEEK PERIOD ENDING 31 OCT 1951
WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE
RATE PER 1000 TROOPS PER YEAR
5 WEEK PERIOD ENDING 31 OCT 1951
NEGRO PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE
RATES PER 1000 PER YEAR
FIVE WEEK & CUMULATIVE TOTALS ENDING 31 OCT 1951
TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



PREVENTIVE MEDICINE

RESTRICTED
SECURITY INFORMATION

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT For the Five Week Period Ending 31 October 1951 (Data from DD Form 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rates per 1000 Troops per Annum
Fort Belvoir	W	15164	3	10	0	13	8.94
	N	2057	3	22	4	29	147.02
	T	17221	6	32	4	42	25.43
Fort McNair	W	828	0	0	0	0	-
	N	76	0	5	0	5	686.05
	T	904	0	5	0	5	57.68
	W	3684	1	2	0	3	8.49
	N	157	0	1	0	1	66.42
	T	3841	1	3	0	4	10.86
US Army Dispensary The Pentagon	W	3952	0	0	0	0	-
	N	18	0	0	0	0	-
	T	3970	0	0	0	0	-
All Others	W	2795	0	0	0	0	-
	N	6	0	0	0	0	-
	T	2801	0	0	0	0	-
Total-Military District of Washington	W	26423	4	12	0	16	6.31
	N	2304	3	28	4	35	157.73
	T	28737	7	40	4	51	18.51
Army Medical Center	W	2909	3	0	0	3	10.75
	N	282	0	1	0	1	36.98
	T	3191	3	1	0	4	13.07
Total-Dept/Army Units	W	29332	7	12	0	19	6.75
	N	2596	3	29	4	36	144.61
	T	31928	10	41	4	55	18.02

VENEREAL DISEASE RATES* (All Army Troops)

	AUGUST	SEPTEMBER	OCTOBER
First Army Area	39	42	30
Second Army Area	27	28	26
Military District of Washington	17	14	18
Third Army Area	26	26	28
Fourth Army Area	35	38	33
Fifth Army Area	28	29	25
Sixth Army Area	40	38	42
TOTAL United States	31	32	30

*Compiled in the Office of the Surgeon General and Includes US Army Hospitals

RESTRICTED
SECURITY INFORMATION

RESTRICTED SECURITY INFORMATION

DENTAL SERVICE

DENTAL SERVICE - FIVE WEEK PERIOD ENDING 31 OCTOBER 1951

STATION	TOTAL DENTISTS		Sittings	Fillings	Bridges	Crowns	Dentures	Calculus	Teeth	Roentgen-	Exami-
	Officer	Civilian						Removed	Removed		
Fort Belvoir	32	0	7833	4866	22	13	197	548	2368	3848	4949
Fort McNair	2	0	447	252	0	2	9	14	58	804	119
Fort Myer, Va.	6	1	2792	870	2	3	48	258	227	1056	823
US Army, Disp.	7	0	1791	776	6	6	23	99	131	900	799
Pentagon											
All Others	4	0	1340	747	4	4	29	76	185	402	661
Total - MDW	51	1	14203	7511	34	28	306	995	2969	7010	7351

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED OCTOBER 1951
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	TOTAL
	3	4	5	6	7	8	9	
Fort Lesley J. McNair		61,790	168,835		213,835		71,357	515,817
Fort Belvoir, Virginia		577,990	525,343		1,070,494	177,383	414,745	2,765,955
Alexandria Field Buying Off.		592,812	277,167	873,386			137,194	1,880,559
Fort Myer, Virginia		140,019	206,465	448	395,324	4,148	81,832	827,788
Cameron Station, Va.		150,515	178,117		319,688	8,836	106,183	763,787
MDW Veterinary Detachment	1,555,947	58,500						1,614,447
The Pentagon						355,505		355,505
Army Medical Center		213,362	159,301		363,230	14,392	71,757	822,042
TOTAL	1,555,947	1,794,988	1,515,228	873,834	2,362,571	560,264	883,068	9,545,900

REJECTIONS:

Not type class or grade								
Alexandria Field Buy. Off.		4,011						4,011
MDW Vet. Detach.	3,070	22,500						25,570
Insanitary or Unsound								
Alex. Field Buy. Off.		10,804						10,804
MDW Vet. Detach.	36,106							36,106
Fort Myer, Va.						99		99
TOTALS	39,176	37,315				99		76,590

*Class 3 - Prior to Purchase

*Class 4 - On delivery at Purchase

*Class 5 - Army Receipt except Purchase

*Class 6 - Prior to Shipment

*Class 7 - Att Issue

*Class 8 - Purchase by Post Exchange, Clubs
Messes or Post Restaurants

*Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the five week period ending 31 October 1951:

ARMY:

Number of Outpatients 18,304
Number of Treatments 22,894

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 3,448

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 11,029

NON-ARMY:

Number of Outpatients 19,701
Number of Treatments 22,096

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 3,448

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 11,029

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	JULY 1951	AUGUST 1951	SEPTEMBER 1951	OCTOBER 1951
Fort Belvoir				
Income per Ration	\$1.3327	\$1.3455	\$1.353	\$1.3232
Expense per Ration	1.2586	1.2556	1.333	1.3335
Gain or Loss	+.0741	+.0900	+.020	-.0105

SIX SURVIVAL SECRETS FOR ATOMIC ATTACKS

ALWAYS PUT FIRST THINGS FIRST AND

NEVER LOSE YOUR HEAD AND

1. TRY TO GET SHIELDED

If you have time, get down in a basement or subway. Should you unexpectedly be caught out-of-doors, seek shelter alongside a building, or jump in any handy ditch or gutter.

2. DROP FLAT ON GROUND OR FLOOR

To keep from being tossed about and to lessen the chances of being struck by falling and flying objects, flatten out at the base of a wall, or at the bottom of a bank.

3. BURY YOUR FACE IN YOUR ARMS

When you drop flat, hide your eyes in the crook of your elbow. That will protect your face from flash burns, prevent temporary blindness and keep flying objects out of your eyes.

4. DON'T RUSH OUTSIDE RIGHT AFTER A BOMBING

After an air burst, wait a few minutes then go help to fight fires. After other kinds of bursts wait at least 1 hour to give lingering radiation some chance to die down.

5. DON'T TAKE CHANCES WITH FOOD OR WATER IN OPEN CONTAINERS

To prevent radioactive poisoning or disease, select your food and water with care. When there is reason to believe they may be contaminated, stick to canned and bottled things if possible.

6. DON'T START RUMORS

In the confusion that follows a bombing, a single rumor might touch off a panic that could cost your life.